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BACK PAIN ASSESSMENT

PERSONAL INFORMATION:

NAME:_____
BIRTH DATE:_____
AGE: _____ MALE_____ FEMALE_____
MARITAL STATUS: ___Married _____Divorced
____Single_____Separated

DATE:_____

BACK SYMPTOMS:

Where is your pain and for how long?

LOCATION	DURATION
NECK	_____
MID BACK	_____
LOW BACK	_____
BUTTOCK OR HIP	_____
DOWN THE LEG	_____
OTHER	_____

_____
_____

Was the onset of your present pain?
__SUDDEN (MIN.) __ SUDDEN(HRS)
__GRADUAL (DAYS) __ GRADUAL(WEEKS)
__OTHER; __ UNKNOWN
_____
_____

What was the cause of your pain?
__UNKNOWN __HIT IN THE BACK
__LIFTING __AUTO ACCIDENT
__TWISTING __BENDING
__FALL __PULLING

Do you believe your pain is related to a work injury?
__NO __POSSIBLE
__YES; DATE INJURED:_____

When having pain is it generally....
__MILD DISCOMFORT OR LESS
__DULL PAIN, WORSE AT TIMES
__HARD ACHING PAIN, FREQUENTLY WORSE
__SEVERE PAIN, SHARP/ SHOOTING AT TIMES
__VERY SEVERE, SHARP, SHOOTING, DISABLING
__SEVERE & DISABLING

NEWBCKWC

How often are you having pain now?
__ RARELY IF EVER
__ OCCASIONAL (1-2 EPISODES PER YEAR)
__ RECURRENT (2-3 DAYS EVERY FEW MONTHS)
__ FREQUENT (>3 DAYS PER MONTH)
__ VERY FREQUENT (EVERY WEEK)

Describe your pain as;

(C) CONSTANT	**(D)DULL**
(I) INTERMITTENT	**(T) THROBBING**
(S) SHARP	**(B) BURNING**

___NECK	___BUTTOCK/HIP
___MID BACK	___ DOWN LEG
___LOW BACK	___ OTHER

_____
_____

What time of day is your pain usually worse?
__MORNING __ SAME ALL DAY
__ MID-DAY __ AT NIGHT IN BED
__ EVENING

What makes your pain worse?
__ LYING DOWN __ BENDING FORWARD
__ SITTING __ BENDING BACK
__ STANDING __ COUGHING
__ WALKING __ SNEEZING
__ LIFTING __ SLEEPING
__ TWISTING __ OTHER
_____
_____

What makes your pain better?
__ LYING DOWN __ BENDING FORWARD
__ SITTING __ BENDING BACK
__ STANDING __ MEDICATION
__ WALKING __ PHYSICAL THERAPY
__ NOTHING __ OTHER
_____
_____

Since the onset, is your pain getting...
__ RAPIDLY WORSE __ RAPIDLY BETTER
__ SLOWLY WORSE __ SLOWLY BETTER
__ UNCHANGED

Since the onset of this episode of pain, have you had any...
__NUMBNESS IN THE FOOT;LEG, RIGHT, OR BOTH
__ NUMBNESS IN LEG; LEFT, RIGHT, OR BOTH
__ BLADDER PROBLEMS
__ BOWEL PROBLEMS
__ PAIN THAT WAKES YOU FROM SLEEP
__ FEVER, CHILLS, SHAKES, SWEATS
PLEASE DESCRIBE, INCLUDE DETAILS AND DATES.
_____
_____
_____

Prior to the onset of this episode of pain, had you noticed any...
__ NUMBNESS IN FOOT; LEFT,RIGHT, OR BOTH
__ NUMBNESS IN LEG; LEFT, RIGHT, OR BOTH
__ BLADDER PROBLEMS
__ BOWEL PROBLEMS
__ PAIN THAT WAKES YOU FROM SLEEP
__ FEVER, CHILLS, SHAKES,SWEATS
PLEASE DESCRIBE, INCLUDE DETAILS AND DATES.
_____
_____
_____
_____

WORK AND RECREATIONAL ACTIVITIES

Are you presently employed?
__ NO; HOW LONG SINCE YOU WERE?
_____

__YES; WHERE AND FOR HOW LONG?
_____
_____

WHAT IS YOUR OCCUPATION?

_____
(**PRESENT)**
_____
(PREVIOUS OCCUPATIONS)
_____

Activities at home or work mostly involve;
__ MANUAL LABOR, HEAVY LIFTING
__ MANUAL LABOR, LESS STRENUOUS
__ SITTING MOST OF THE DAY
__ WALKING OR STANDING MOST OF THE DAY
__ HOUSE WORK AND CHILD CARE
(#_____CHILDREN)

How is the pain limiting your job and/or home activities?
__ NOT LIMITED IN ANY WAY
__ NOT LIMITED MUCH DUE TO PAIN
__ ABLE TO WORK AROUND THE PAIN
__ MUST STOP AND LIMIT ACTIVITIES
__ UNABLE TO WORK FOR DAYS AT A TIME
__ UNABLE TO WORK AT ALL DUE TO PAIN

Has your present episode of pain prevented you from working your regular job?
__ NO
__ NOT APPLICABLE
__ YES; HOW MANY WORK DAYS MISSED?
_____

What activities have you enjoyed in the past that pain prevents you from enjoying today?
_____
_____

How much is your pain limiting your social, recreational, and other activities?
__ NOT LIMITED IN ANY WAY
__ NOT LIMITED MUCH DUE TO PAIN
__ ABLE TO DO MOST THINGS WITH THE PAIN
__ MODIFY ACTIVITIES TO CONTROL THE PAIN
__ GREATLY LIMIT ACTIVITIES TO CONTROL PAIN
__ UNABLE TO PARTICIPATE IN ANY ACTIVITIES

EVALUATION & TREATMENT

What other medical/osteopathic doctors, Chiropractors have you seen for your problems?
(List names and dates)

Doctors:_____
_____
_____
_____

Chiropractors:_____
_____
_____
_____

What studies have been done?
(List where and when)
__ NONE
XRAY;_____
CT SCAN;_____
MYELOGRAM;_____
MRI SCAN;_____
BONE SCAN;_____
EMG;_____

What treatment have you received?
(List by whom and when)
__NONE
MANIPULATIONS;_____
BRACE/CORSET;_____
PHYSICAL THERAPY;_____
SPINALBLOCK;_____
HOSPITALIZED;_____
OTHER;_____

Do you take any medication for your pain?
__NO
__ YES; LIST MEDICATIONS AND DOSAGES
_____
_____

Have you had back surgery?
__ NO
__ YES; LIST TYPE, DATE AND SURGEON.
DID IT HELP YOUR PAIN?_____
_____
_____
_____

PAST MEDICAL HISTORY:

Please rate your general health.
__ EXCELLENT __ FAIR
__ GOOD __ POOR

Do you have any medical problems for which you regularly see a doctor?
__ NO
__ YES; LIST DOCTOR AND PROBLEM:
_____
_____
_____

Have you had surgery?
(OTHER THAN BACK SURGERY)
__ NO
__ YES; LIST TYPE, DATE, AND SURGEON:
_____
_____
_____

Have you ever been seriously injured?
__ NO
__ YES; DETAILS AND DATES:
_____
_____
_____

Have you ever been hospitalized?
__ NO
__ YES; WHEN AND WHERE:
_____
_____
_____

Do you have any allergies to medications?
__ NO
__ YES; LIST DRUG(S) AND REACTION(S):
_____
_____
_____

Please list your current medications and dosages.
_____
_____
_____
_____
_____
_____

Have you ever been evaluated/treated for substance (drugs/alcohol)dependence?
__NO
__ YES; WHEN, WHERE, AND BY WHOM?
_____
_____
_____

Have you ever been treated for emotional/psychiatric problems?
__ NO
__ YES; WHEN, WHERE,A ND BY WHOM?
_____
_____

Did you suffer any unusal childhood illness?
__NO
__ YES; WHAT AND WHEN?
_____
_____

FAMILY HISTORY:

Are there any medical problems that tend to run in your family?
__ NO
__ YES; LIST FAMILY MEMBER AND CONDITION:
_____
_____

Do back problems tend to run in your family?
__ NO
__ YES; LIST FAMILY MEMBER AND CONDITION:
_____
_____
ANY BACK SURGERY? __NO __ YES

SOCIAL HISTORY:

What is the highest level of education you have completed?
__ GRADE SCHOOL __ COLLEGE
__ HIGH SCHOOL __ GRADUATE SCHOOL
__ TRADE SCHOOL

Do you like you work?
__ YES
__ NOT APPLICABLE
__ NO; WHY NOT?
_____
_____

Do you like your boss/supervisor?
__ NO
__ NOT APPLICABLE
__ YES

In the past have you been unable to work because of pain?
__NO
__ NOT APPLICABLE
__ YES;HOW MANY DAYS TOTAL
_____

Have you had past work related back injuries?
__NO
__ YES; LIST HOW AND WHEN_____
_____
_____

Do you exercise on a regular basis?
__ NO
__ YES; DOING WHAT, HOW MANY DAYS/WEEK?
_____
_____

Do you smoke or chew tobacco?
__ NO
__ YES; HOW MUCH?
_____

Do you drink alcohol (beer, wine, liqueur)?
__ NO
__ YES; HOW OFTEN /MUCH

Have any of the following reasons caused you to be emotionally upset recently?
__ NOT UPSET __ MARITAL __SOCIAL
__ WORK __ LEGAL __ FINANCIAL
__OTHER_____
_____

If your condition does not improve, what will your future plans include?
_____
_____
_____

Do your religious beliefs prevent you from receiving blood transfusion if medically necessary?
__ NO
__ YES

MEDICAL LEGAL INFORMATION:

Have you ever been involved in a medical law suit?
__ NO
__ YES; PLEASE EXPLAIN
_____
_____

Are you involved in a medical lawsuit now?
__NO
__ YES; PLEASE EXPLAIN.
_____
_____

Is an attorney currently involved with your back problem?
__ NO
__ YES; PLEASE EXPLAIN
_____
_____

REVIEW OF SYSTEMS:

PLEASE INDICATE IF YOU NOW HAVE (OR HAVE HAD IN THE PAST)PROBLEMS WITH ANY OF THE FOLLOWING;

__ WEIGHT LOSS
__ WEIGHT GAIN
__ FEVER, CHILLS, SWEATS
__ POOR CIRCULATION
__ DEPRESSION
__ VISION
__ SEVERE INDIGESTION
__ NOSE BLEEDS
__ DENTURES/CAPS
__ LOOSE TEETH
__ CHIPPED TEETH
__ JAW PAIN
__ NECK PAIN
__ ASTHMA
__ EMPHYSEMA
__ BRONCHITIS/PNEUMONIA
__ CHEST PAIN
__ HEART ATTACK/HEART FAILURE
__ HEART MUMMUR
__ ARRYTHMIA
__ HIGH BLOOD PRESSURE
__ HEADACHES
__ STROKE
__ BLOOD TRANSFUSION

__DIABETES
__ THYROID DISEASE
__ SLEEP
__ MUSCLE CRAMPS
__ HIATAL HERNIA
__ STOMACH ULCER
__ LIVER DISEASE
__ HEPATITIS
__ GALL BLADDER
__ PANCREATITIS
__ BOWEL DISEASE
_DRK/BLOODY STOOL
__ PELVIC PAIN
__ KIDNEY STONES
__ BLADDER
INFECTIONS
__ HISTORY CANCER
__ ARTHRITIS/GOUT
__ SEIZURES/FITS
__ WOUND
INFECTIONS
__ ANESTHESIA
__ AIDS/HIV

SELF ASSESMENT

Please describe how you have felt during the PAST WEEK by checking the appropiate box.

	NOT AT ALL	A LITTLE	A LOT	ALL THE TIME
FEELING HOT ALL OVER	◊	◊	◊	◊
SWEATING ALL OVER	◊	◊	◊	◊
DIZZINESS	◊	◊	◊	◊
BLURRING OF VISION	◊	◊	◊	◊
FEELING FAINT	◊	◊	◊	◊
NAUSEA	◊	◊	◊	◊
PAIN IN THE STOMACH	◊	◊	◊	◊
CHURRING IN STOMACH	◊	◊	◊	◊
MOUTH BECOMING DRY	◊	◊	◊	◊
NECK MUSCLES ACHING	◊	◊	◊	◊
LEGS FEELING WEAK	◊	◊	◊	◊
MUSCLES TWITCHING & JUMPING	◊	◊	◊	◊
TENSE FEELINGS ACROSS FOREHEAD	◊	◊	◊	◊
I FEEL DOWN-HEARTED BLUE & SAD	◊	◊	◊	◊
MORNING IS WHEN I FEEL BEST	◊	◊	◊	◊
I HAVE CRYING SPELLS OR FEEL LIKE IT	◊	◊	◊	◊
I HAVE TROUBLE SLEEPING AT NIGHT	◊	◊	◊	◊
I HAVE LOST MY APPETITE	◊	◊	◊	◊
I STILL ENJOY SEX	◊	◊	◊	◊
I HAVE TROUBLE WITH CONSTIPATION	◊	◊	◊	◊
MY HEART BEATS FASTER THAN USUAL	◊	◊	◊	◊
I FEEL TIRED FOR NO REASON	◊	◊	◊	◊
I HAVE TROUBLE DOING THINGS I USED TO	◊	◊	◊	◊
I AM RESTLESS AND CAN’T KEEP STILL	◊	◊	◊	◊
I AM HOPEFUL ABOUT THE FUTURE	◊	◊	◊	◊
I AM MORE IRRITABLE THAN USUAL	◊	◊	◊	◊
I FIND IT EASY TO MAKE DECISIONS	◊	◊	◊	◊
I FEEL THAT I AM USEFUL AND NEEDED	◊	◊	◊	◊
MY LIFE IS PRETTY FULL	◊	◊	◊	◊
I STILL ENJOY THINGS I USED TO	◊	◊	◊	◊
FEEL OTHERS WOULD BE BETTER OFF IF I DIED	◊	◊	◊	◊
I NOTICED I HAVE LOST WEIGHT	◊	◊	◊	◊

Please indicate by a mark on the bar below, how much pain you are presently getting from your back on average.

0 10

◊ ◊

NO PAIN WORST PAIN

At present, are you working ?
(House wives and retired persons relate activity to previous abilities)

__FULL TIME AT USUAL JOB
__ FULL TIME AT A LIGHTER JOB
__ PART TIME
__ NOT WORKING

At present, can you undertake household chores or odd jobs?

__ NORMALLY
__ AS MUCH AS USUAL BUT SLOWLY
__ A FEW, NOT AS MANY AS USUAL
__ NOT AT ALL

At present, can you undertake sporting or social pursuits? (e.g. dancing)

__ AS MUCH AS USUAL
__ ALMOST AS MUCH AS USUAL
__ SOME, MUCH LESS THAN USUAL
__ NOT AT ALL

How often have you seen a doctor or had treatment (e.g. physical therapy) for your pain?

__ NEVER
__ RARELY
__ ABOUT ONCE A MONTH
__ MORE THAN ONCE A MONTH

How often do you take pain killers for pain?

__ NEVER
__ OCCASIONALLY
__ ALMOST EVERY DAY
__ SEVERAL TIMES EACH DAY

Do you have to rest during the day because of pain?

__ NO
__ A LITTLE
__ HALF THE DAY
__ OVER HALF THE DAY

Does your pain regularly disturb...

SOCIAL ACTIVITIES __NO __YES
SEXUAL ACTIVITY __NO __YES
SLEEP __NO __YES

Activity level on average is best described as;

__ BEDRIDDEN
__ WHEELCHAIR BOUND
__ HOUSE BOUND
__ LIGHT PHYSICAL ACTIVITY
__ LIGHT WORK
__ LIMITED MEDIUM WORK
__ MEDIUM WORK
__ HEAVY WORK WITH PAIN
__ NO LIMITATION

Please mark any activities that you <u>can</u> do;

__ LIFT A SMALL (3 YEAR OLD) CHILD
__ SIT FOR HALF AN HOUR
__ STAND IN ONE PLACE FOR HALF AN HOUR
__ TRAVEL IN A CAR OR BUS FOR HALF AN HOUR
__ WALK 500 YARDS
__ PUT SHOES AND SOCKS ON WITHOUT HELP
__ GENERAL HOME MAINTENANCE
__ (i.e. VACUUM, WASH DISHES, LAUNDRY)

How does pain effect the following activities?

	severely impossible	**moderately difficult**	**mildly not much**	**not at all**
SLEEPING	◊	◊	◊	◊
WALKING	◊	◊	◊	◊
SITTING	◊	◊	◊	◊
DRIVING	◊	◊	◊	◊
DRESSING	◊	◊	◊	◊
SEX LIFE	◊	◊	◊	◊
WORK	◊	◊	◊	◊
SPORTS	◊	◊	◊	◊
EXERCISE	◊	◊	◊	◊

PAIN SCALE:

*** How much of your total pain is from your back, and how much is from your buttock,hip, or leg?**

100% **TOTAL** PAIN=_____% BACK PAIN + _____% BUTTOCK ,HIP, OR LEG PAIN.

*** Please rate your pain when it is <u>LEAST</u> bothersome by placing a single mark on scale below.**
(0 = NO PAIN) **(10= WORST PAIN IMAGINABLE)**

_____

0 1 2 3 4 5 6 7 8 9 10

***Please rate your pain when it is <u>MOST</u> bothersome by placing a single mark on the scale below**

_____

0 1 2 3 4 5 6 7 8 9 10

PAIN DRAWING :
On the figures below please indicate where you are having any:
***Draw arrows to show where pain goes or shoots**
***Please indicate where the pain is worse**
***Be sure to show ALL areas involved**

ACHING/PAIN (XXXX)
NUMBNESS/TINGLING (0000)
PINS/NEEDLES (.....)
BURNING (////)
SPASM/CRAMP (<u>∇∇∇∇</u>)